STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505418	A. BUILDING _____ B. WING _____	C 08/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE MARIANWOOD	3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This report is the result of an unannounced Abbreviated Survey conducted at Providence Marianwood on 08/08/2013. A sample of 4 residents were slected from a census of 117.

The following complaint was investigated as part of this survey:

2824808

The survey was conducted by:

[redacted] RN, BSN
Nursing Home Complaint Investigator
Department of Social and Health Services
Aging and Disability Services Administration
Residential Care Services
20425 72nd. Ave. S, Suite 400
Kent, WA 98032

Phone: (253)234-6000
Fax: (253) 395-5085

Residential Care Services 8/23/13 Date

RECEIVED
SEP 03 2013
DSHS/ADSA/RCS Region 4

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	**How the Nursing Home will correct the Deficiency as it relates to the Resident:** • Gait Belt was removed from resident • On 8/9, incident report reopened and full investigation conducted to include interviews of resident family, staff, and residents significant other • On 8/9, DSHS Hotline notified of incident with follow-up provided **How the Nursing Home will act to protect residents in other situations.** • LTC Compliance Manager has reviewed the incident and DSHS reporting requirements with involved staff members to include staff members A, B, C and F. • LTC Compliance Manager held debrief meeting with staff members A, B, and C on incident to include 8/9 investigation findings and summary • Facilitated meeting between nursing and therapy management team on findings of investigation to include; failure to identify incident as abuse/neglect, failure to report to DSHS Hotline, failure to investigate or establish "origin or cause", breakdown in established roles and responsibilities of a mandatory reporter, and ineffective communication between staff for the management of Phase I and II investigations	

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F 225	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to fully investigate the use of a gait belt to restrain a resident (Resident #1) in her wheelchair. Failing to thoroughly investigate the circumstances of using the gait belt as a restraint device without an assessment of need and consideration of alternatives placed the Resident at risk for injury, harm, and overall decreased quality of life. Findings include: Resident #1 was admitted to the facility for [redacted], and a history of [redacted] On 08/01/2013 at 04:15 PM the Resident was found by the CNA (certified nursing assistant) to be restrained in her wheelchair with a gait belt. The incident investigation showed the daughter "likely did it." The report goes on to say "the patient came from the hospital where the daughter witnessed this being done to keep her mother from falling." The Resident had been ordered to have a chair alarm only. There was no assessment for the use of the restraint device and the investigation showed that all staff denied placing the device on the Resident. On 08/08/2013 at 3:15 PM Staff C the Director of Rehabilitation stated they determined that the daughter applied the restraint. When asked if someone spoke to the daughter to verify this, she stated she told a member of the PT staff to call her. She verified there was no documentation of this conversation. In a conversation with Staff F,	F 225	**Measures the Nursing Home will take or systems it will alter to ensure that the problem does not recur.** • Provide focused training to clinical staff on findings of the investigation to include; identification of abuse/neglect, reporting of events, Phase I & II investigations, and effective communication • Continue to monitor and redirect suspected LTC resident who was identified in the investigation and has a known history of attempting to assist other residents **How the Nursing Home plans to monitor its performance to make sure that solutions are sustained.** • TCU and LTC Managers to monitor staff for appropriate use of gait belts and report any inappropriate findings to the DNS for immediate action • Director of Clinical Services and LTC Compliance Manager will establish regular weekly schedule to review DSHS Log and investigations for compliance with DSHS Guidelines **Date when corrective actions will be completed:** August 9, 2013 – Investigation and summary completed September 20, 2013 - Facilitated meeting and training completed	

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F 225	Continued From page 3 PT (physical therapy) she stated that no one had called the daughter. Staff C then acknowledged that no one had attempted to contact the daughter to determine if she had applied the restraint. Staff B, the Administrator verified that the investigation was not thorough. On 08/13/2013 at 10:45 AM, in a phone conversation with Staff A, the Director of Nursing, when asked how the Resident got the restraint she stated "I don ' t know." She stated "I can ' t tell you why no one verified it." She stated that since 08/08/2013 they spoke with the daughter who stated she did not apply the gait belt. The facility failed to conduct a thorough investigation before concluding that Resident #1 ' s daughter restrained the resident using the gait belt.	F 225	**Title of the person responsible for ensuring completion:** Colleen Hardy, RN, MBA, DON **How will the Nursing Home correct the deficiency as it relates to this resident?** • The medications were delivered by the pharmacy on 7/15 but stored in incorrect location • Medication moved to medication cart with the appropriate labels • Resident received her eye drops as ordered until discharge **How the Nursing Home will act to protect other residents in similar situations?** • Staff training will be done with all LNs on the TCU to cover what actions to take when medications are not available to administer	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide ordered medications for Resident #1 who required treatment for [redacted]. Failure to ensure the Resident received the medications to treat her [redacted] placed the Resident at risk for increased intraocular (eye) pressure and negative effects on her already compromised vision.	F 333		

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F 333	Continued From page 4 Findings include: Resident #1 suffered from [redacted] as well as other medical conditions. She was prescribed 3 types of eye drops (C[redacted] and [redacted] to treat her [redacted]. These medications prevent increases in her eye pressure. In addition, she was to receive another medication, Atropine to treat eye inflammation and pain. A review of the facility medication administration records for this Resident showed the Resident did not receive several doses of these medications from 07/15/2013 through 08/03/2013. She missed a total of 3 doses of Cosopt, 6 doses of [redacted] doses of [redacted] and 3 doses of [redacted] for a total of 14 missed doses. A review of the Medication Administration Record showed documentation by the nursing staff that the medications were not administered because they were not available. There was no record of any attempts by the staff to obtain the medications from the pharmacy or to or to notify the doctor to determine if another medication could be substituted. In an interview with Staff A, the Director of Nursing on 08/13/2013 at 10:45 AM she was unable to state why no one had followed up. When asked why no one had followed up she stated "I can't tell you." She acknowledged that the physician had not been contacted to obtain an alternative medication.	F 333	**Measures the Nursing Home will take or systems it will alter to ensure that the problem does not recur.** • Staff training will be done to re-educate nurses on the appropriate storage of medications that are delivered so they are safe and readily accessible **How the Nursing Home plans to monitor its performance to make sure that solutions are sustained.** • Random audits (at least 5) of TCU charts will be performed weekly to determine that medications that are ordered are available and administered **Dates when this will be completed :** September 20, 2013- **The title of the person responsible to ensure correction** [redacted] Director of Clinical Services	